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2012-2013 Annual Report

South East Local Health Integration Network

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Board of Directors

Donna Segal (Chair)
Appointed: 21 December 2012
Term Expires: 20 December 2015

Andreas von Cramon (Acting Chair/Vice Chair)
Appointed: 28 April 2010
Term Expires: 27 April 2013

Arthur Ronald
Appointed: 10 August 2010
Term Expires: 9 August 2013

Ian Fraser
Appointed: 15 September 2010
Term Expires: 14 September 2013

David Sansom
Appointed: 4 May 2011
Term Expires: 3 May 2013

Lois Burrows
Appointed: 21 November 2012
Term Expires: 20 November 2015

Len Kennedy
Appointed: 21 December 2012
Term Expires: 20 December 2015

Janet Cosier
Appointed: 1 February 2013
Term Expires: 31 January 2016

Jyoti Kotecha
Appointed: 24 March 2010
Term Expired: 23 March 2013

Wynn Turner (Past Chair)
Appointed: 1 November 2009
Term Expired: 31 October 2012

Senior Executive

Paul Huras
Chief Executive Officer

Sherry Kennedy
Chief Operating Officer

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Message from our Board Chair/CEO

We are pleased to submit our 2012-2013 Annual Report for the South East LHIN.

This past year has been remarkable for the ways in which the pace of change in striving for integrated care in our communities has continued to surge. We have made great strides in laying the groundwork for our third Integrated Health Services Plan and the strategy it sets out for our way forward. The LHIN's evolving programs and new initiatives have supported and will continue to contribute to the collective quality and availability of health and community services in our region. The introduction of our Health Links initiatives across the South East has begun to foster a stronger collaboration of Primary Care practitioners with other related services, in particular so that our most vulnerable and needy residents receive the care they need, effectively and efficiently. We are proud of our leadership position in the province in developing and implementing the Health Links concept, just as we appreciate and are honoured by the vote of confidence in our capacity as a regional innovator with the transition to our mandate of the Diabetes Regional Control team.

At the same time, we continue to see gratifying results from the momentum we have already established in areas such as our Behavioural Supports approach; the steady progress in the patient-navigation role of our SE CCAC; and the benefits that are accruing to residents of this region from the action plans and programs arising out of our Clinical Services Roadmap.

This change has required that we, too, evolve in order to better interpret and meet the vision of our residents. We have committed to an ever-stronger collaborative approach, an openness and inclusiveness which is evidenced by the efforts of the Board, its Collaborative Governance and Community Engagement Committee and, on the ground, the LHIN professional staff. We will continue to reach out to – and meet with an enthusiastic response from –our Health Service Provider partners across our region.

Fiscal year 2012-2013 has been an exciting and rewarding year.

While we work hard to maintain our momentum, we have come to understand more clearly that "past is prologue" as we see how the hard work and determination invested in the programs and initiatives undertaken in the past, will lead us, collectively, towards continued and expanding improvements to our local healthcare system in the future.

And, as always, we recognize and applaud the relentless commitment and dedication of our health service partners; the cooperation and support of the Ministry of Health and Long Term Care that sustains the good we do; and the passion of our SE LHIN staff in working to achieve the best health delivery system possible for the 500,000 residents of this region.

Donna Segal

Paul Huras

Donna Segal, Board Chair

Paul Huras, CEO,

Overview

FACTS & FIGURES

Population (2013)

FUNDING *(Allocated to Health Service Providers – 2012/13)* **$1,099,257,331**

Providers

7 Hospitals operating 11 Sites
1 Community Care Access Centre (South East)
36 Long Term Care Homes

Community Agencies

34 Community Support Service agencies
3 Acquired Brain Injury (ABI) Programs
3 Assisted Living/Supportive Housing Programs
8 Addictions Program agencies
5 Community Health Centres
16 Mental Health Program agencies

Funding by Sector (2012/13)

Operation of Hospitals	$721,433,597
Municipal Tax Grants – hospitals	$ 190,725
Long Term Care Homes	$170,990,709
Community Care Access Centre	$108,497,833
Community Support Services	$ 32,180,853
Community Health Centres	$ 23,054,049
Community Mental Health	$ 35,978,875
Addictions Program	$ 6,930,690
Total Funding Allocated	**$1,099,257,331**

Percentage Funding by Sector – 2012/13

Operation of Hospitals	65.6%
Municipal Tax Grants – hospitals	0.02%
Long Term Care Homes	15.6%
Community Care Access Centre	9.9%
Community Support Services	2.9%
Community Health Centres	2.1%
Community Mental Health Programs	3.3%
Addictions Program	0.6%

Community Overview

At 19,473 square kilometers, the South East LHIN is the fourth largest local health integration network by geographic area. We serve approximately 3.8% of Ontarians who live, in almost equal proportion, along a ribbon of more urban areas following Highway 401, or in small rural communities located across the remainder of the area.

The LHIN geographic area includes the communities bounded by towns of Brighton and Cardinal from east to west, and from Prince Edward County to just north of Lake St Peter from north to south. LHIN geographic areas were determined based on where residents predominantly received their care. The vast majority of SE LHIN residents receive their required medical care from providers in the region. For services received in hospitals, the percentages of SE LHIN residents receiving care from South East providers range from 85% for inpatient rehabilitation to 98% for complex continuing care.

Accountability and responsible health system management

LHINs were developed with accountability as a core value. *The Local Health System Integration Act, 2006* specifies the powers of the LHIN Board to make decisions regarding the local health system, within the provisions of the *Act* and under the stewardship of the Ministry of Health and Long-Term Care. The LHIN is required to engage in consultations with its communities as part of its strategic planning and priority setting cycles. Decisions of the LHIN must be made in full consideration of the public interest.

Every three years, LHINs develop an updated Integrated Health Service Plan (IHSP) – that defines our strategic objectives for the local health system. The IHSP provides a framework for the LHIN and this region's health service providers to ensure that time, effort and resources are appropriately aligned.

Each LHIN has a Performance Agreement between itself and the Minister of Health and Long-Term Care. That agreement specifies the obligations of both parties, as well as identifies areas where the ministry wants to see improvement. Performance indicators, along with multi-year targets, are set out in this agreement, and the results are reported publicly, through this report and other channels.

As a Provincial Crown Agency, the LHIN is fully responsible for following Directives from the Province of Ontario regarding allocation of funding, operational spending, tendering for third party services, hiring, and other policies that are directed towards Ontario's agencies, boards and commissions.

The Chief Executive Officer of each LHIN has quarterly meetings with senior ministry officials to brief them on the impact of the LHIN's activities, highlighting successes as well as opportunities for greater improvement.

The LHIN Board of Directors has ultimate accountability to the Minister of Health and Long-Term Care. All major decisions taken by the LHIN are directed by our Board. Our CEO provides monthly updates on operational activities, reports on performance indicator results, and provides updates on our progress towards achieving our IHSP priorities.

Within this accountability framework, the South East LHIN Board has set in place four corporate strategic goals:

To build a true system of integrated health care that optimizes the use of resources

To build understanding of the role of the SE LHIN in developing and managing a regional system of integrated patient-centred care in collaboration with Health System providers

To build a functional integrated health information system that supports better health care services and healthier citizens

To demonstrate leadership as a knowledge–based organization that is professional, proactive and responsive.

LHIN Board members, executive, and staff are fully briefed on our accountability relationships and are required to incorporate the requirements contained in them into their relationships with our HSPs, as well as into their work activities.

As important and necessary as these formal accountabilities are, they do not directly speak to our most important accountability – to the residents who live within our geographic area.

The Board and staff of the South East LHIN are also residents of this community. We share the vision of an accessible and sustainable health care system expressed by residents.

Being accountable is more than reporting the right numbers. In the South East LHIN, it means making decisions that will have a positive impact on the quality and sustainability of the health system. It means making things work better, and doing what makes sense.

Meeting provincial standards

The South East LHIN has worked diligently with health service providers to ensure that provincial standards of care are met by addressing local healthcare needs. We have been innovative so that our engagement with our communities was significant and meaningful, allowing us to develop an approach that accurately reflects community input. We have looked beyond Ontario's borders to find models, programs and processes that have been proven to provide services more efficiently and effectively, or which help people avoid typical — but preventable —reasons for accessing the health care system. Our objective is to enhance and evolve the local health care system to ensure it meets, and continues to meet, the needs of our residents.

Major accountability projects

As part of our mandate, the South East LHIN has undertaken a number of projects that support our accountability relationships, priorities for change at a health systems level, or improve our overall understanding of the local health care system. In 2012/13, the LHIN engaged in several projects of this type.

South East Community Care Access Centre (CCAC) Performance Assurance Review (PAR)

One critically important aspect of the South East LHIN's commitment to ensuring that residents of this region have access to the support services they may require is our obligation to monitor the performance and efficiency of the Health Service Providers who are charged with the responsibility of delivering that support. In response to a number of concerns regarding the South East CCAC's ability to meet their clients' needs consistently and effectively, the SE LHIN enlisted the help of an independent management consulting group to conduct an objective review of that organization's strategic and operational performance.

The results of that performance (PAR) review led to changes in CCAC leadership and the implementing of an overall, ongoing, improvement plan that has yielded highly-positive results. During FY 2012/13 the South East CCAC completed the final few initiatives as part of the implementation plan developed jointly with the SE LHIN. Successful implementation of changes in business intelligence and client services have allowed the South East CCAC to become a leader provincially in these areas and the SE LHIN is confident that the continued spread and sustainability of improved capacity will position the South East CCAC as a leader in the region.

Additionally in 2012/13, preliminary groundwork was completed for the eventual realization of an enhanced role for the CCAC that will empower this organization to broaden its patient placement service into hospitals, specifically CCC, rehab and convalescent care beds.

Community Services Back Office Project

As part of our accountability agreements with community providers, each participated in an exercise to determine what core administrative services could be combined and shared through a common 'back office'. The intent of the project was to determine how much could be saved by the system by, for example, having a single payroll system, or a common bookkeeping office. Phase I of this project, which involved an assessment of what back office services could be shared, was completed in 2009/10.

Phase II, the development of options for a back office approach, culminated in the Fall of 2010, with the SE LHIN Board approving the implementation of initiatives such as a common purchasing plan, models for transactional accounting services, and a shared benefits plan.

Phase III, the implementation of these initiatives, has been completed and they are now

fully operational. Analysis and feedback to date have identified financial savings, but the largest benefit has been increased capacity within the community sectors allowing agencies to provide more front line care to clients and patients.

Shared Support Services of Southeastern Ontario (3SO)

Similar in nature to the Back Office Project, 3SO is a collaboration of the South East LHIN hospitals to create a shared back office for purchasing and procurement services. 3SO, employing staff who are expert in procurement, leverage the purchasing power of all the hospitals, allowing hospital management to direct their attention to their core business of providing excellent patient care. During fiscal 2012/13, 3SO expanded its services beyond core medical/surgical suppliers to encompass substantially *all* procurement activities for many of its member hospitals.

Service Accountability Agreements (H-SAAs, M-SAAs, L-SAAs)

With the enactment of the *Local Health System Integration Act, (LHSIA)* in 2006, the LHINs assumed full responsibility for planning, funding and integrating health services in their geographic areas.

In fulfilling that responsibility, they began the negotiation of service accountability agreements (SAAs) between themselves and the health service providers (HSPs) they funded. The Hospital SAAs (H-SAAs) were extended for an additional year in 2012-13. Multi-sector SAAs (M-SAAs) were negotiated with community support services agencies, community care access centres, community health centres and community mental health and addictions agencies for 2011-14. For the final year of this agreement the Provincial and Local obligations were updated (refreshed) to bring them into line with current provincial priorities.

In 2012, the SE LHIN successfully renewed the Long-Term Care Home (LTCH) Service Accountability Agreements (L-SAAs) with 36 Long-Term Care Homes in the south east. This sector plays a role in enhancing the stability and accountability of our health care system, and supports the alignment of health services across the various sectors.

Report on IHSP2

The second Integrated Health Services Plan (IHSP2) for the South East LHIN was completed in 2009. It built upon the progress made to improve local health care since the first IHSP was approved in October 2006.

In preparing this plan, we conducted extensive research on the health of our residents to find out what health care services they used. We talked to Ontarians who live in the communities we serve, to gain their views about the local health care system. We asked what was good about health-care locally and what could use improvement. We also asked what the future local health-care system should look like. Finally, we consulted with our providers to gain their perspective of the local health-system's strengths, opportunities for improvement and generally how well they saw the system meeting people's needs.

The outcome of this research was IHSP2, and the Ten Priorities that have directed the LHIN's activities from FY2010/11 through the end of FY2012/13. A full copy of IHSP2 is available at www.SouthEastLHIN.on.ca

We are very proud of the accomplishments that our health service providers have made, and that we have achieved collectively over the past four years. The results speak to the dedication and commitment of every health-care provider in this LHIN, as well as to all the administrative, operations, and support people behind them.

One of the concerns raised in health-care is that there is so much change, people just can't keep up. We think our results tell a different story. Change for the sake of change is not sustainable. However, change that fits with a vision of success *is* sustainable. Change linked to a clearly articulated goal, with a way to measure progress towards that goal, can energize people.

There is nothing stagnant about health-care. Medical discoveries have not slowed down over the last 20 years. Surgical residents today are not learning the same techniques and approaches that their teachers learned. Everything in health-care is changing all the time. The LHIN's role is to ensure that change is focused on what is important to the health-care needs of our residents now and in the future.

IHSP2 told us that the system was, largely speaking, doing what it was supposed to do. Our job in IHSP2 was not to create a new local health-care system, but to 'renovate' the existing one.

In all, there are ten priorities set out in IHSP2 to assist the South East LHIN in creating an accessible and sustainable system for care. In turn, these priorities will also position care so that it is provided in the right place at the right time. These system improvements will enable the acute care system to be better able to focus on its role.

Our report on IHSP2 is listed by each of the ten priorities identified in it, and a summary of key activities supporting those priorities.

1. *Developing a System of Primary Health Care*

Access to Primary Care has been identified as an immediate priority in IHSP2 since it deals with most health problems encountered by most people most of the time and is often the main entry point into the healthcare system. As such, Primary Care must be accessible whenever health needs arise; it must focus on individuals over the long term; and it must offer comprehensive care for all health problems.

Activities supporting this priority

Health Care Connect: Healthcare connect is a provincial service, conceived and developed in the South East LHIN, that provides a means for Ontarians to obtain a primary health care practitioner without having to canvass all local Physicians.

In 2007, many Ontarians living in the South East LHIN did not have a primary health care provider. As of March 31st, 2013, over 98% of those who wanted a primary health care provider had been referred to one – the third-highest such rate in the province.

Primary Health-Care Council: The South East LHIN, in conjunction with Queen's Family Health Team (FHT), established our Primary Health Care Council three years ago. The Council is charged with the responsibility of advising the LHIN on how best to build a system of primary care. It is comprised of primary care providers from across the LHIN. In April, 2013 the Council will have hosted the fifth Annual Primary Health Care Forum, providing an opportunity for researchers, policy decision makers and members of the primary health care community to meet and discuss areas of mutual interest. The PHC Vision is that of *"Collaborative primary care leadership towards an integrated, patient-centred, high quality health care system."*

Health Links: On December 7, 2012 the Ministry of Health and Long Term Care announced the creation of *Health Links* to improve the co-ordination of care for patients with complex conditions.

Across the province as well as here in the South East, these new Health Links will encourage greater collaboration and co-ordination between a patient's different health care providers as well as the development of personalized care plans. This will help improve patient transitions within the system and help ensure patients receive more responsive care that addresses their specific needs with the support of a tightly knit team of providers.

Within the South East LHIN, the December announcement included three groupings that were accorded Health Links in this region: *Quinte Health Link* which has identified priorities in Palliative Care, Hospital at Home, a CHF Primary Care Clinic, community-based Cardiac rehab, and Mental Health and Addictions; *Rural Hastings Health Link* with priorities in chronic disease prevention and management, care coordination, Palliative/End of Life care, data quality, and patient engagement in service design and evaluation; and *Rural Kingston Health Link*, with priorities in chronic disease management, a CHF clinic, palliative care and care coordination. While these priorities could certainly evolve to reflect the changing needs of their respective communities, they provide a solid starting point for optimizing the delivery of primary care.

In addition to these three initial Health Links, the South East made further progress in the latter part of 2012/13 in moving towards the establishment of another two Health Links, the *Kingston Health Link* and the *Thousand Islands Health Link.* Plans were also laid for the foundation of two other Health Links in the south east which are expected to achieve status in FY 2013/14.

Primary Care Lead in the South East LHIN: Having appointed Dr. Jonathan Kerr as its Primary Care Lead in February, 2012, the South East LHIN took a major step in strengthening and further integrating primary care into local health planning. In the relatively short time during which he has been active in this role, Dr. Kerr has become a key player – and the driving force – in moving forward with gains being made within the Primary Health Care Council and in the organization and development of this region's Health Links initiative.

2. Enhancing a Culture of Patient-Centred Care

The need for patient-centred care is commonly expressed by the public as an expectation of our health-care system. Patient centred or patient directed care includes good "customer" service, access and responsiveness. It also includes assistance in navigating and coordinating the many components of care or treatment a patient may require to maintain or improve health. Patient centred care is about quality service and quality care, where the needs of the patient and the population drive the utilization and deployment of resources. Within the South East LHIN, a culture of patient centred care must be fostered to ensure our system is integrated and appropriately responds to the needs of the individual and the population.

Activities Supporting this Priority

Health Links: As described in the previous section.

Wait List Management: The South East LHIN has maintained the requirement of hospitals providing services funded under Ontario's Wait Time Strategy to audit their wait lists to ensure that anyone waiting longer than 180 days was reassessed.

Excellent Care for All Act (ECFAA): Since this Act came into effect in July, 2010, the South East LHIN has been active in educating and promoting to our HSPs the spirit and requirements of the legislation; and assisting our Hospitals with the review of their Quality Improvement Plans (QIPs).

Senior-Friendly Hospitals: The *"Senior-Friendly Hospital"* philosophy introduced in 2010 has found expression in the SE LHIN's Clinical Services Roadmap Restorative Care work plan. SELHIN Hospitals, the SECCAC and Behavioural Supports Ontario are focused collaboratively on two key senior-friendly themes: preventing functional decline and managing delirium.

Improved coordination of care: Work done as part of the SELHIN's Clinical Services Roadmap workplans also concentrated on improving the communication and cooperation between hospital emergency departments, hospital discharge planners, CCAC case coordinators, community service support case coordinators and primary care practitioners within the LHIN. An integrated community assessment referral team was established to ensure seniors who visit ERs are screened for high risk of poor outcomes if an intervention doesn't occur. This team coordinates care in the community sector to ensure the senior gets the support they need to recover and live at home. This includes coordinating support from the CCAC, CSS and Primary Care agencies.

Enhancing Hospice Palliative Care: In December 2012, a decision was made to align the planning and implementation accountabilities for palliative and end-of-life care system development with those of the SE LHIN. Accordingly, in March 2013, the South East Palliative and End-of-Life Care Network (SE PEOLCN) Steering Committee sunsetted the existing Network and all committees reporting to it. It was agreed that a transition plan to enable the creation of a new regional hospice palliative care planning framework would be developed collaboratively. A Transitional Committee, comprised of key representatives from the existing steering committee, was formed to facilitate this shift. They will guide the next phase of planning and partner engagement while sustaining a focus on hospice palliative care system development in the South East going forward.

3. Improving Mental Health and Addictions Services Capacity

In keeping with the planned development of the 10-year strategy on Mental Health and Addictions for the province, the South East LHIN will focus its efforts on integrating mental health and addictions services across the levels of care and with the main health-care system. Our efforts will focus on early identification and intervention in a seamless system of comprehensive, effective, efficient, proactive and population-based services and supports by revaluating current resources.

Activities Supporting this Priority

Behavioural Support Services: In August, 2011 the South East LHIN was chosen as one of four early-adopter LHINs to implement the Behavioural Supports Ontario (BSO) project, investing $2.42 million to enhance services for seniors who exhibit behaviours associated with complex and challenging mental health, dementia or other neurological conditions.

Health providers in the SELHIN have demonstrated leadership and shared knowledge, experience and strategies that have been emulated in other areas of the Province. Recently, the BSO Provincial Coordinating and Reporting Office (CRO) identified the SELHIN as a leader in this area, providing insights and mechanisms for adoption in other LHINs in the transition from the planning to implementation stage of BSO. Some of the service improvements achieved over FY 2012/13 include:

BSO Connect
A Regional intake and triage service (access and transition) was established as a 24/7 service that is now available for Long-Term Care.

BSO Mobile Response Teams focusing on Long-Term Care.
The South East has led the Province in implementing a 24/7 Resource Service for Long-Term Care to support service needs, enhance capacity and address the issue of equity and access as well as timeliness of response. The regional BSO Mobile Team is fully operational and, in the last quarter of 2012/13, provided 1500 responses with one of the highest timeliness ratings in the province.

Primary Care, integrated care development.
South Eastern Ontario has embraced the concept of integrated care management, moving away from the concept of collaborative and shared care. This approach has been validated as effective, using significant scientific rigour thanks to a Canadian Institute Health Research grant, leveraged with Providence Care resources, to initiate a process

that will provide increased access, timeliness of response, and a continuous flow of new knowledge into day-to-day practice. This has involved activities in Family Health Teams and Family Practices across the region, as well as discussions with Prince Edward County surrounding the Hospital and the Home initiative.

Hospital within the health system.
A multi-faceted approach to enhanced capacity and service has been developed by Providence Care in the South East LHIN, and is being implemented at KGH and in Quinte. At KGH, this approach focuses on Elder Care, environmental design and person-centred care. At Quinte, the approach has manifested itself in the Senior Friendly initiative.

Mental Health and Addictions Services Redesign: During the public consultation undertaken in preparing for our third Integrated Health Services Plan (IHSP3), our residents, clients and patients, primary care providers, and current MHA service providers all indicated that, while the care received at any one provider has been very good, the current patchwork of providers and services does not serve the residents of the South East as well as it could.

In particular, feedback from our community engagement activities has reflected concerns with: duplication of services, duplication of assessments (multiple story telling), difficulties in transitioning between providers, difficulty in accessing services, insufficient volume of services to satisfy demand, and the stigma often faced in accessing mental health and addictions services.

To address these issues, in February 2013 the SELHIN engaged KPMG to assist in the development of a project plan to guide the MHA providers and the LHIN in redesigning mental health & addictions services across the region. KPMG staff engaged stakeholder representatives including providers, psychiatrists, primary-care providers and clients to inform the development of the project plan itself. The final project plan was delivered on March 31, 2013. The second phase (Phase 2), the development and finalization of the Redesign Plan, began on April 1st, 2013 and is targeted for completion by the end of December 2013.

4. Developing Regional Program Management

Residents of Southeastern Ontario express a need for improved access. What they often mean is enhancing capacity or providing more service. Access can be improved, capacity enhanced and service increased through better system management of our current

regional resources. This is the concept of getting more from what is available. Regional program management is about managing health services, which may currently be managed separately in two or more sites across our region, as one program. It includes services that are delivered in multiple sites and are integrated across the region depending on volumes and availability of resources.

Regional program management would allow for a clinical and administrative lead to facilitate the development of a common vision and targets, thus improving accountability for service performance across the region.

Activities Supporting this Priority

The South East LHIN Regional Clinical Services Roadmap: As the catalyst to achieving a truly regionalized system of integrated health care the Regional Clinical Services Roadmap (CSR) has been the mainstay of the SE LHIN's strategic activities throughout much of the past three years.

At the outset of FY 2012-2013, eighteen of the thirty-two CSR initiatives were prioritized for Wave One implementation. The remaining initiatives will be considered for Wave Two implementation at a later date.

During the year many changes occurred at the provincial and local levels of healthcare. Although it is somewhat early to weigh their impact on the south east healthcare system, it is expected to be significant. The recently-announced Healthlinks approach, for example, will have an impact on a number of the CSR projects. And the announcement of the future MHA redesign has added a new dimension to existing CSR MHA initiatives.

Other changes, including the renewed Provincial Cardiac Care Network strategy, and the Ontario Seniors Care Strategy, ultimately had a significant effect on the timing, focus, and structure of a number of the CSR projects.

Much work remains to be done before reaching the end state visions outlined for many of these projects, and while enthusiasm remains high on most initiatives, others will face challenges in this and future waves.
The CSR leadership group championed various initiatives, liaising closely with their respective nursing staffs, medical colleagues, SECHEF and community organizations. They also oversaw progress at individual sites, providing advice and feedback to the CSR Project Management Office (PMO), and escalating any implementation issues along the way.

Of particular note has been the support of the senior leadership, operational work teams, and clinical leadership teams. The 'buy-in' from those forming and leading the work teams has been the driver of the various initiatives. It has been these leaders who have shifted the thinking from the individual organizations' needs, to those of the patient and region as a whole.

The notion of regional networks (supporting ongoing quality and process improvement) was tabled early on in the project. This idea, although supported in principle, is still evolving. To date, the Maternal and High Risk New Born (MHRNB) work team has developed terms of reference which have been approved by SECHEF.

A CSR Logic Map has evolved that aligns provincial and regional priorities with short to mid-term process outcomes, and long term system outcomes. LHIN CSR measurables will be incorporated into health service provider accountability agreements.

Detailed on-line documentation of the active Wave One initiatives and other relevant project information is available through the CSR-Sharepoint site and provides web access to the most appropriate CSR team members. As well, the CSR project coordinators are using Eclipse, a web-based tool, to record and monitor work plans on each of the CSR initiatives and to record progress and track issues.

Surgery planning for the South East Clinical Services Roadmap is moving forward with the commitment of the region's hospital executives and SE LHIN to develop agreements for a number of the surgical specialties with General Surgery as the front runner. This work follows on the regional surgery videoconference that was held Oct 23rd 2012 to provide information on provincially-driven funding changes, orthopaedic capacity planning and an introduction to the General Surgery Agreement. The proposed specialty agreements will build on the foundation of the SE Regional Surgery Charter and take into consideration the need for regional capacity planning, as well as the provision of regional urgent and emergent care.

On a positive note, given the ongoing complex and dynamic environment in which healthcare organizations find themselves, much progress has been made towards the adoption of the concept of integration of services and programs across the region. Leaders across the south east's health care organizations have, to a large extent, embraced the philosophy of thinking regionally, acting locally.

Community Engagement

In preparation for the development of its third Integrated Health Services Plan (IHSP3) that defines the strategic direction for the delivery of health care from April 1st 2013 until March 31st 2016, the SE LHIN initiated a Public and Community Engagement exercise in June and July of 2012 similar in style to the highly-successful model used for the LHIN's Clinical Services Roadmap in 2011.

A dedicated website was established and went live for a period of six weeks, during which residents across this region were invited to visit the site, learn about healthcare priorities and challenges, then complete an online workbook that captured their concerns and opinions for improvement. At the end of the engagement period, the results and commentaries were analyzed, and a number of themes emerged that guided the LHIN in determining which strategic priorities should be pursued.

Of particular importance to this community engagement process was the inclusion of Francophone residents who were engaged through face-to-face focus group discussions; and Aboriginal residents who participated in a series of Visioning Circle meetings.

The rich, detailed commentary arising from this community engagement process has served the LHIN well in understanding where to focus resources and energies in order to best meet the healthcare needs of our population across the South East.

5. ***Improving Access to Emergency Rooms***

Emergency Departments are seen as the "canaries in the mine" of the health-care system. That means if something is not right with the local health system, it is often exposed from one's experience in the emergency room. When appropriate access to and flow through an emergency room is timely and successful, the public is confident that the health system is functioning well. A truly integrated health-care system makes the most effective use of the emergency rooms. We have an opportunity to improve access to and from the emergency room. All LHINs view this as an essential priority for change.

Activities Supporting this Priority

Reducing ER Visits: Because the majority of clients visiting the ER repeatedly are seniors over the age of 65 who live alone (or in long-term care housing), attention focused on the percentage of clients known to the CCAC who were visiting emergency rooms; when the visits took place (and for what reasons); and the circumstances that caused them to

seek care. Understanding these factors has guided changes in resources and processes to help ensure patients receive the right care at the right time in the right place.

ED-CCAC Notification System: Prior to 2012-2103, there was no timely process for informing hospital personnel that an Emergency Department patient was also a CCAC client. Nor was there any consistent method for informing CCAC Care Coordinators their client had gone to the ED and when, or if, they would return home.

Now, however, when a match such as this occurs, the ED CCAC notification system sends an automatic, secure, notification to the ED and the CCAC health care providers – giving both care teams a better understanding of the patients' needs for ER care as well as community supports. Sharing this information in this manner creates a hospital and community team approach to determine what is needed for the patient to return home safely after their ED visit, and to prevent potential future visits. It also ensures the discharge patient is followed up with promptly once they're home.

Using leading practices, this partnership is helping to manage the transition of patients from home to acute care facilities, and back to their home safely, reducing or postponing the need for admission to long-term care homes.

Nurse Led Outreach Teams: Most frail seniors in the SE LHIN live in Long Term Care Homes. Their care needs are high, require frequent assessments and monitoring, and can require treatments that LTCH staff are not familiar with or comfortable administering. Hence, many LTCH residents who fall ill are sent to ER to receive care. This practice does not provide optimal care for the frail LTCH senior -- nor is it the best use of ambulance or hospital resources. Nurse Led Outreach Teams (NLOTs) were developed in 2009 and expanded in 2012/13 to reduce unnecessary ER visits and optimize LTCH resident care.

Over 70% of the SELHIN Long Term Care Homes are supported by a Nurse Led Outreach Team and the NLOT program is intended to build capacity among Long-Term Care Home staff to improve system flow, prevent avoidable Emergency Room visits and ensure that Long-Term Care Home residents receive access to timely, high quality care within the comfort of their daily environment.

The NLOT model of care has not only reduced high & low acuity ER visits by LTCH residents – it has educated LTCHs about the role of nurse practitioners, and established best practices for fall prevention, incontinence, hypoglycemia, early sign of pneumonia and other top reasons for ER visits. Over 500 clients have been cared for by these specialized teams, along with over 350 LTCH staff members being educated on care

pathways and when to link with the NLOT. The recent development of a LTCH family advisory council in some homes has aided nurse practitioners in facilitating better communication around end of life/palliative care. Managing these clients in their (LTCH) is best for the client, their family and the healthcare system.

SMILE Program: SMILE *(Seniors Managing Independent Living Easily)* is a program that originated in the SE LHIN. It enables seniors to live independently in their own homes by providing them with support services for household tasks they may not be able to perform for themselves, such as mowing a lawn or shopping for groceries. The SMILE Program coordinating agency provides these types of services above and beyond those already provided by CCAC and CSS agencies. SMILE enables clients to choose the particular provider they want to deliver their services within their allotted budget. Since its launch over five years ago, the number of patients/clients receiving SMILE services has grown to 1700 – 1800 per year, resulting in many clients removing their name and application from long-term care waitlists.

Senior Wrap-Around Care: Within a community health care setting, a specially-trained team of health professionals and volunteers aid seniors and their caregivers to identify their specific needs, strengths, culture and preferences for who it is that provides them with community support. These providers, selected by the senior and caregiver, are pulled together into a community team of formal and informal members to implement the care plan designed for the senior as they continue living in the community. Preliminary findings from this program indicate more seniors are staying in their homes and communities longer, and the incidence of ER visits and hospital admissions has been reduced.

Early detection, timely care for High-Risk Seniors: The early identification of high risk frail-elderly patients by ED staff can lead to an assessment for the community home support services they'll need if they are discharged from the ED -- or an inpatient assessment that will activate a care plan to prevent functional or cognitive decline.

Discharged hospital high-risk clients are put in touch with an *Integrated Community Assessment Referral Team* (iCART), who assess clients from CCAC and CSS services. Care is provided through this integrated team, whose members share assessments and care plans to avoid duplication of services, client confusion and to ensure the client is visited appropriately to diminish anxiety, prevent social isolation and avoid their seeking help through the ER for non-acute care needs.

System-wide Patient Flow Improvements; Through the SELHIN Clinical Service Roadmap ER Wait Times workplan, initiatives have been designed to improve discharge planning, internal hospital patient flow, reduced patient length of stay, performance accountability frameworks and fast access and care for lower-acuity ER clients who will not be admitted. These initiatives have improved the timely access to care that patients need.

Emergency Department - Capacity & Performance

Understanding the patient flow within an Emergency Department has helped the SE LHIN understand and improve upon our ED Wait Times.

Pay for Results (P4R): The two largest EDs in our region received *Pay for Results* (P4R) funding in 2012/13. Kingston General Hospital (KGH) had achieved patient flow improvements, noting a reduction in average length-of-stay for patients. This was achieved through their-short stay unit initiative, along with the implementation of their Medical Program Care navigators who facilitate patient discharges. In 2011/12 KGH improved on their non-admitted patients and achieved reductions in the time it takes to see a physician. But with the increased volumes seen in ER and the increased number of readmits to hospital, the previously efficient Fast Track unit for low-acuity non-admitted patients was no longer effective. Efforts to re-establish this unit continued throughout 2012/13.

At Quinte Health Care – the Belleville and Trenton sites continued to improve on all aspects of ED Wait Times. Initiatives such as the Green Zone and Rapid Assessment Unit have brought significant improvements, even with the additional challenge of a 10% increase in patient volumes. Physician engagement has also improved with new senior leadership which has aided in overall patient flow. Senior leadership has embarked on a performance accountability structure that supports corporate initiatives with open communication, performance monitoring and frontline-driven processes.

Transition of Client Care: Through process-improvement initiatives, the SELHIN has been working with the SECCAC and CSS agencies in developing better ways of transitioning clients through the system. This has been accomplished in a number of ways, including; learning how to better share patient information while at the same time supporting the patient's right to privacy; providing care in an equitable and timely fashion; ensuring standardized assessments are performed; and supporting prompt patient referral to other agencies when a need has been identified.

6. *Reducing the Incidence and Prevalence of Alternate Level of Care*

When someone is placed into an acute care bed who does not need acute care or someone stays in an acute care bed when they no longer require acute care, the patient and the system are both compromised. The patient may lose strength or acquire an infection and the system loses or misuses valuable capacity. All patients should be appropriately placed in the setting that best fits their care needs.

Activities Supporting this Priority

An important cultural paradigm shift has taken place throughout the SE LHIN – one that attempts to ensure every patient gets the opportunity to go home first, before any Long Term Care Home setting is discussed.

The SELHIN has adopted the Home First philosophy in all seven regional hospitals, featuring a collaborative approach with the SECCAC and Community Support Services. Through an integrated discharge planning process, patients at high risk of being designated as ALC, are being identified earlier to avoid the physical and cognitive decline that can accompany a lengthy hospital stay. This process also helps avoid inappropriate ALC designation or delays in discharge. Programs included in this planning process are *Home First,* and *Enhanced Activation Therapy.*

Home First: As outlined above, the *Home First* philosophy enables frail seniors to return home following an acute-care hospital stay, rather than being sent to a LTCH. It speaks to the cultural paradigm shift that sees many patients going home after their hospital care, whereas in the past they would have had to wait in hospital for a long-term care home bed to become available.

First launched at QHC in 2009/10, *Home First* has since been adopted across the SELHIN. This has led to a gradual reduction in the number of patients being designated as requiring ALC over this past year. By improving hospital-to-community discharge processes and access to community services, the "home first way" has seen a reduction in unnecessary hospitalization.

Furthermore, a significant percentage of those seniors who went home thanks to *Home First* are still in their homes. This has reduced the demand for long-term care home beds, which, in turn, will enable those who *do* need that level of care to get it sooner. This is borne out in the following results:

- As of March 2013, the South East LHIN reported over 970 seniors were assessed to go Home First, before any other discharge destination was determined. Of these 970 hospitalized frail seniors, 56% returned home.

- Of those remaining in hospital, 17% were ineligible for returning home because of challenging behaviours that would require intensive LTCH care. It is important to note that this patient population is one of the reasons the SELHIN ALC days have increased significantly, going from FY 2012- 13 Q1 – where it sat at 12.1%, to a Q3 level of 13.86%. The number of clients displaying challenging or responsive behaviours remains relatively stable; however, their hospital stays are longer. Additional analysis and work is needed to further reduce the number of clients remaining in hospital, along with a reduction in their associated length of stay.

- 27% remaining in hospital presented with barriers that prevent them from going home. The majority of these clients and/or their families were not comfortable about care being delivered at home. Despite intensive counselling and maximum service provisions, their decision was to remain in hospital until long term care beds become available.

For SE LHIN residents, adoption of the Home First philosophy has ensured that patient flow is improving and more patients are receiving the right care at the right time in the right place. For seniors residing in the South East, Home First has provided them the opportunity to go home after an acute event with appropriate community supports and services that enable them to remain at home as long as they wish.

Discharge Link: *Discharge Link* was launched in February, 2009, to provide enhanced community-based rehabilitation services for stroke survivors living at home and in long-term care homes. Services provided through this program include physiotherapy and access to occupational health and social workers. Initial evaluation has demonstrated a reduction in Length of Stay (LOS), fewer readmissions through Emergency Departments, and overall better patient outcomes.

The *Discharge Link* model of care has been adopted for high-risk frail seniors who require intense rehabilitation therapy through the Enhanced Activation Therapy program, while they are in hospital, to help them avoid decline. It also coordinates community services to ensure patients continue to strengthen or maintain their physical and cognitive abilities.

Enhanced Activation program: is provided in three SELHIN hospitals to reduce the functional decline of seniors and reduce their anxiety over how they will manage at home after being discharged from hospital. Enhanced Activation ensures that clients are assessed, while in the hospital, for their ability to function at home. Therapy is provided to improve the patient's functional ability and to ensure they continue to receive therapy once they are home. The success of this program is to be found in the number of patients who are able to return home (and remain there) with very few readmissions. Less than 10% of patients receiving enhanced activation return to hospital within 30 days of being discharged.

Overall, the South East LHIN's focus on system patient flow is intended to meet or exceed Ontario's targets for wait times and access, while also meeting local health care needs.

7. *Implementing the Ontario Diabetes Strategy*

Due to the high prevalence and impact of diabetes in this region, an essential first step into chronic disease management will be to focus on this serious disease. We have opportunities to integrate diabetes care and the monitoring of management indicators. Lessons learned will drive other chronic disease management strategies.

Activities Supporting this Priority

Diabetes Regional Coordination Centre transitioned to SE LHIN : On January 31st, 2013 the Ministry of Health and Long Term Care announced that the operational mandate and funding of the South East Diabetes Regional Coordination Centre (SE DRCC) was transitioned to the South East LHIN. The move brought six full time staff positions to the LHIN's Belleville office where they have been working to support improved coordination of care for people living with diabetes, and to streamline services provided to individuals at risk of developing (or living with) the disease.

Alignment with the Ontario Diabetes Strategy: Diabetes is a serious chronic disease that is costly to the individual, their families and society alike. Patients living with diabetes are encouraged to self-manage their disease by making healthy lifestyle choices and by taking medication if needed.

Because of its complex nature, effective management of the disease and the avoidance

of serious complications requires access to a range of health-care services. Patients with diabetes within the SE LHIN will benefit through improved health promotion, prevention, increased access to diabetes care and more coordinated services to help them manage the disease.

Diabetes Self-Management Initiative: Hosted by the Kingston CHC. The aim of the Ontario Diabetes Strategy Self-Management Initiative is to provide support, tools and expertise to foster self-management capability. This includes capacity building for service providers, communities and individual diabetics through: training and coaching/mentoring of multidisciplinary service providers to integrate self-management approaches into their practice; and training of Peer Leaders and Master Trainers to increase access to, and delivery of, Chronic Disease Self-Management Skill Building Group Programs for individuals with diabetes.

8. Furthering Access Through E-health

E-health is a key enabler to achieving an integrated system of care. E-health will ultimately produce an electronic health record, but will also advance the electronic transfer of diagnostic requests and results, standard referral protocols, timely communication between professionals, and rapid access to current research. The South East LHIN will advance its e-health strategy in coordination with the provincial e-health strategy. E-health will lead and enable the diabetes strategy roll out. E-health will also lead and enable the regional surgical program e-referral initiative. Further, e-health will lead and enable initiatives to develop primary health care as a regional system of care.

Note: Since this priority was first identified as part of IHSP2 there has been a shift in direction in the overall Provincial Diabetes Strategy that has reduced the role of e-Health in the roll out of that strategy. All other aspects of the SE LHIN's priority of "Furthering Access Through E-health" remain the same.

Activities Supporting this Priority

Clinical Document Repository: The Champlain LHIN and the South East LHIN partnered in creating a Clinical Document Repository (CDR) for Eastern Ontario. The CDR is a regional repository of the key patient records that are most commonly shared among healthcare providers across the continuum of care for those patients. This is a key component in the development of an electronic health record for residents of Eastern Ontario. Current phases of the CDR project are extending the ability of the existing Eastern Ontario hospitals and physicians to share electronic clinical documents.

Base Information Technology Initiative: The LHIN has facilitated this initiative that will support the hospitals in the LHIN to make it easier to share health records across the continuum of care. BITI initiatives allow easier sharing of information among the hospitals of the SE LHIN. This includes steps that will ease integration of IT networks, user identification and user access, all while adhering to strict standards of privacy.

Resource Matching and Referral: The SE LHIN has actively engaged in this provincial initiative through membership on the RM&R Steering Committee and through partnership with the North and Eastern Ontario LHIN cluster. The LHIN has engaged with HSPs in this region to develop standard RM&R processes and forms that will inform and guide the implementation stage as the initiative develops and progresses.

cNEO Regional Clustering: The SE LHIN is also actively engaged with partner Northern and Eastern Ontario Cluster LHINs in the cNEO project. The cNEO Project will plan and implement a provincial standard "system integration hub" for the area. Aligned with eHealth's Blueprint and standards, the primary goal of the project is to provide Health Service Providers (HSPs) with timely access to personal health information (in compliance with privacy legislation) from across the continuum of care and at any point of care throughout the "cluster." The four LHINs will work collaboratively to plan, establish and deploy integrated Electronic Health Record (EHR) services through a "hub" composed of Provincial standards-based "Cornerstone" solutions: Portal, Health Information Access Layer (HIAL), Clinical Document Repository (CDR) and other services. With reliable and secure electronic health information, HSPs will have more comprehensive information to deliver better and more coordinated patient care.

9. *Expanding Culturally and Linguistically- Sensitive Healthcare Services*

The South East LHIN is committed to working with French language communities and the health providers serving them to ensure there is appropriate access to care in the French language. Equally, the South East LHIN will work with its Aboriginal communities to offer assistance in their efforts to ensure appropriate access to care.

Activities Supporting This Priority

Further Development of French Language Services: Database analysis revealed that a linguistic variable needed to be added to the administrative databases used by the LHINs for planning. Accordingly, the entity charged with the responsibility for ensuring the availability of French-language health services in eastern Ontario, the Réseau, developed an Excel tool to inventory survey data on the Francophone population. The tool will be used by the SE LHIN FLS Coordinator and the Réseau team to inform our planning initiatives.

In collaboration with the province's other five FLS Planning Entities, an environmental scan was conducted on other provincial research stakeholders to determine partnership opportunities. These other provincial Entities were also surveyed on their research priorities.

The SELHIN and the Reseau continued to work with *Association Canadienne-Française de l'Ontario* (ACFO) Mille-Îles on their two population surveys already in progress. At the same time, there was participation by the group in a research coordination meeting organized by the *Consortium National de Formation en Santé* (CNFS) in support of an integrated subsidy application for primary care. Also, in collaboration with the Société Santé en français, guidelines were developed for French-language mental health services.

The SELHIN FLS Coordinator and the Reseau finalized the establishing of a French Language Citizens' Advisory Committee to provide guidance, feedback and suggestions on the manner in which the development of French language health services could best serve francophone residents throughout the south east. During FY 2012/13 the mandate of the Citizens' Committee was ratified, the committee itself was formed, and its first two initial meetings were held.

Throughout the public engagement conducted in the development of the LHIN's IHSP3, the Reseau and the SELHIN FLS Coordinator promoted francophone participation in the LHIN's online workbook questionnaires, and in conjunction with regional francophone groups, provided written recommendations arising out of their face-to-face meetings and discussions with these residents.

Engagement with Aboriginal Populations: Regular meetings between the SE LHIN Board Chair, CEO and staff continued throughout FY 2012/13 with the Chief and Council of the Mohawks of the Bay of Quinte, with a focus on improved relationships and the identification of areas of support for their strategic plan.

With the key assistance of the South East Indigenous Council in planning and organizing a series of three Visioning Circles, the LHIN was able to hear first-hand, as well as to learn more about and understand in rich detail, the healthcare realities and concerns expressed by south east Aboriginal residents. These discussions provided valuable input to – and assisted in identifying priorities for – the development of the IHSP3.

10. Advancing System Improvement Through Boards Working Together

The role of health-care governance is evolving in the LHIN environment, where boards are not just responsible for overseeing the management of their own organization, but also for contributing to the development and functioning of an integrated system of care. The South East LHIN will continue to nurture an environment where Boards are working together to lead and support integration and system development.

Activities Supporting This Priority

Collaborative Governance: As part of its determination to strengthen collaborative governance and working relationships with Health Service Providers across the south east, the SE LHIN Board formed a Collaborative Governance & Community Engagement (CGCE) Committee of the Board in FY 2011/12.

The committee seeks to engage with HSP partners in developing good governance principles of integration, collaboration, systems thinking, quality care and patient safety in ways that will achieve tangible progress within all sectors of the south east health care delivery system. Whether by helping to coordinate a system-wide approach to health planning, or paving the way for integration initiatives, the Collaborative Governance & Community Engagement Committee looks for ways to establish a common platform on which the Boards of Health Service Providers can work closely and effectively with the LHIN Board in improving access to quality care for residents of the region.

The sectors represented on this committee include Community Support, Public Health, Long Term Care, Community Health Centres, Other Primary Care providers, Hospitals, the CCAC, Mental Health and Addictions, Academia and the community at large. The CGCE Committee also includes representatives from the SE LHIN to sit as Co- Chairs, ex-officio members and resource staff.

In the latter part of 2012 the Committee organized and staged a number of information sessions entitled *"Working Towards Better Health"* that provided HSP participants with a progress report on IHSP2, and explored themes to be considered for inclusion in the development of IHSP3. These sessions were held:

- October 18th, 2012 in Belleville
- October 24th, 2012 in Smiths Falls
- October 30th, 2012 in Kingston

The Collaborative Governance and Community Engagement Committee holds as its Mission Statement:

"To engage the regional community, HSPs and additional provider agencies and organizations, in a way that encourages the development and implementation of governance-based integration initiatives, puts emphasis on the integration of patient pathways, and strengthens communications and builds leadership within local communities."

The committee has also articulated its primary goals as:

- **Goal 1:** *To promote excellence in HSP Board Governance*
- **Goal 2:** *To facilitate mutual understanding among Boards of agencies included in Health Links*
- **Goal 3:** *To promote the SE LHIN and local HSPs in establishing and achieving regional healthcare goals.*

These goals were agreed upon and approved by the committee in March, 2013.

The South East LHIN Knowledge Management Team

The vision of the Knowledge Management Team is to support the South East LHIN objectives through the collecting, accessing and reporting of comprehensive, accurate, health and related data; developing reliable information management solutions; and providing leadership in data analysis and statistical consultation to staff, health service providers and other stakeholders.

In the 2012/13 fiscal period the main activities of this team included:

Database/System Development and Management: Given the importance of timely access to key health system utilization, health status and socio-demographic data to the LHIN's planning, performance and funding mandates, the Knowledge Management Team continued its Database Development efforts with the implementation of the Microstrategy Business Intelligence Solution. The system incorporates data on priority performance measures as well as population estimates and projections. It's accessible to all LHIN staff and while it is structured to provide dashboard summary results for senior staff – it also has the capability to be drill down into more detail for analytical

investigators as required. Over the next year the Team will incorporate other LHIN datasets into this tool which will provide access to key statistics at the fingertips within seconds. This will greatly enhance staff's ability to gather the information required to support many programs while improving overall efficiency within LHIN operations.

Project Support: The most significant project undertaken by the Knowledge Management Team in the last year was the update to the Regional Capacity Assessment and Projection Report. This not only involved the estimation of SubLHIN Projection Forecast for 2011-2021 but also the updating of Sector Profiles (ER, Acute Inpatient, Day Procedures, Inpatient Rehabilitation, Complex Continuing Care, Acute Adult Mental Health, Community Health Centres, Home Care, Community Support Services and Long Term Care) as well as Reports on Health Status and Risk Behaviors, High-User Utilization, Francophone and Aboriginal Profiles and Human Resources in the Health System. Other noteworthy activities included:

- Cluster Analysis to determine geographic areas with similar primary health care access patterns as well as relatively homogeneous socio-economic groupings.
- Target Setting and performance monitoring for MLPA and SAAs
- Technical oversight for Stocktake Reports
- Review of utilization levels for Capital Projects
- Indicator Development support for Behavioral Support Systems
- Performance Management Indicators for Primary Health Care Leads
- Primary Care Performance Management Committee representation
- Review of Data Collected on the Francophone population in Provincial and Regional Health System Databases and Surveys
- Analytical Support to Metis Nations Ontario Survey Report
- Addictions and Substance Abuse Utilization Report
- Mentoring and supervision of Placement students from Queen's University

SOUTH EAST LHIN PERFORMANCE INDICATORS
2012/13 ANNUAL REPORT
May 13, 2013 Release

PI No.	Performance Indicator	LHIN 2012/13 Starting Point	LHIN 2012/13 Performance Target	Most Recent Quarter 2012/13 LHIN Performance	FY 2012/13 LHIN Annual Result
Emergency Room/Alternate Level of Care					
1	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution*	11.87%	**9.46%**	13.86%	13.37%
2	90th Percentile ER Length of Stay for Admitted Patients	25.30	**22.90**	27.57	24.93
3	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients	6.88	**6.80**	6.57	6.78
4	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients	4.27	**4.00**	4.00	4.05
Surgical Wait Times					
5	90th Percentile Wait Times for Cancer Surgery	52	51	55	50
6	90th Percentile Wait Times for Cardiac By-Pass Procedures	47	51	35	33
7	90th Percentile Wait Times for Cataract Surgery	113	97	120	114
8	90th Percentile Wait Times for Hip Replacement	127	141	158	141
9	90th Percentile Wait Times for Knee Replacement	135	145	141	139
Diagnostic Wait Times					
10	90th Percentile Wait Times for Diagnostic MRI Scan	72	63	41	47
11	90th Percentile Wait Times for Diagnostic CT Scan	21	22	19	20
Excellent Care for All/Quality					
12	Readmission within 30 Days for Selected CMGs**	17.13%	**16.50%**	18.66%	17.70%
Mental Health and Substance Abuse					
13	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions**	20.13%	**18.90%**	17.72%	18.49%
14	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions**	16.64%	**16.50%**	22.39%	21.80%
Access to Community Care					
15	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	23	**22**	21	22

*FY 2012/13 is based on most recent four quarters of data (Q4 2011/12 - Q3 2012/13) due to availability

**FY 2012/13 is based on most recent four quarters of data (Q3 2011/12 - Q2 2012/13) due to availability

The above table provides the available results of key performance indicators in the Ministry-LHIN Performance Agreement (MLPA) for the 2012/13 fiscal period. For the majority of priority surgical and DI procedures (including cancer surgery, cardiac by-pass, hip and knee surgeries and CT/MRI diagnostic scans) the LHIN has achieved the expected regional wait time targets. Monitoring and sustaining these levels (to be determined in the 2013/14 MLPA) will remain an important priority for the 2013/14 period.

LHIN Commentary on Performance Indicator Results

Other key performance indicators in the MLPA have tended to fluctuate around desired targets. Each of these indicators are presented below along with a review and steps to address gaps in performance.

Cataract Surgery Wait Time	Target		LHIN Performance					Result	
	Province	LHIN	Start	Q1	Q2	Q3	Q4	Province	LHIN
90th Percentile Wait (days)	182	97	113	104	121	111	120	134	114

Cataract Surgery Wait Times: The 90th percentile wait time for completed cataract surgery procedures fluctuated moderately over the year - from a starting point of 113 days – with a final LHIN wait time of 114 days. The SE LHIN remains well below the provincial target and current provincial performance. A decrease in cataract volumes allocated to the SE LHIN in FY 2012/13 by MOHLTC has contributed to this increased wait time for cataract surgery

Repeat ER Visits for Substance Abuse (within 30 days)	Target		LHIN Performance					Result	
	Province	LHIN	Start	Q1	Q2	Q3	Q4	Province	LHIN
	TBD	16.5%	16.6%	23.2%	22.4%	NA	NA	28.6%	21.8%

Repeat Unscheduled Emergency Visits within 30 days for Substance Abuse Conditions: Repeat unscheduled emergency visits for substance abuse conditions have increased over the year from a starting point of 16.6% to 21.8% at year-end. This remains below the provincial value of 28.6%. Tying system performance to local initiatives is hampered by the substantial delay introduced by the method of calculating this indicator. The latest results are for Q2 of the past fiscal year and any system improvements will not yet be evident in this metric.

During FY 2012/13, however, the Addictions Supportive Housing (ASH) group continued to accept clients into their housing program. Also, the Crisis Diversion workers hired by Frontenac Community Mental Health and Addictions Services (FCMHAS) working at KGH expanded their reach with two additional Crisis Diversion workers. These additional staff will work to divert Addictions clients to appropriate community services (e.g. Hotel Dieu, FCMHAS and the Detox Center). And finally, the Clinical Services Roadmap Emergency Department (CSR ED) working group has committed to the creation of care plans and a database at Kingston General Hospital - that will be shared with Mental Health and Addictions agencies and updated as the client progresses with treatment (or other events occur).

'Alternate Level of Care' Days

Percentage of Total Acute Days

Target		LHIN Performance					Result	
Province	LHIN	Start	Q1	Q2	Q3	Q4	Province	LHIN
9.46%	**9.46%**	11.9%	12.1%	13.2%	13.9%	NA	**13.9%**	**13.4%**

Percentage of ALC Days: The South East LHIN has set a very aggressive target for this metric – equal to the provincial target of 9.46% -- and is one of only 4 LHINs to have set a target at or below the provincial target. In past years, hospitals across the South East LHIN struggled with this patient population, with ALC percentages approaching 20%. More recently, with focused effort across a range of Health Service providers, this metric has ranged as low as 10.2%. Sustaining that focus and results has proven difficult. Yet at 13.4%, the LHIN remains below the provincial value of 13.9%.

Optimal patient flow can easily be affected by changes in healthcare provider policies, reduced availability of resources or a misalignment between client needs and appropriate services. The SELHIN ALC percentage increase occurred through a combination of these reasons. Furthermore, in FY 2012-13, the SELHIN lost 78 long term care beds, necessitating long ALC stays in area hospitals. Additionally, there was an evident temporary loss of focus on the Home First philosophy in a region of the LHIN. Concerted effort was focused on behavioural and complex needs clients (who are difficult to place in LTC and the community) with a specific effort to ensure that appropriate resources were available within their community to meet their specific needs after an acute-care stay. Although the SELHIN moved quickly to reinforce the Home First philosophy, the remaining ALC challenges will take additional time to correct, but should reduce our numbers of ALC patients, and their associated days, once more.

SE LHIN Operational Performance

Funding Allocation
Total: $5,898,368
Base: $4,543,169
Project: $1,355,199

South East LHIN management administered an allocation of $5,898,368 in fiscal year 2012/13; this represented a 5% reduction in allocation from prior fiscal period. The allocation is comprised of the LHIN's total corporate operational budget of $4,543,169 along with special ancillary project-based funding totaling $1,355,199.

Ancillary Project-Based Funding

The LHIN received special funding for projects supporting Ministry of Health and Long-Term Care health system priorities, as well as the LHIN's Integrated Health Services Plan *"Priorities for Change"*. These projects included:

- Enabling Technologies Project Management Office (formerly known as eHealth PMO)†
- Chronic Disease Management & Diabetes Strategy
- Emergency Room / Alternative Level of Care Strategy†
- Emergency Department Initiative†
- Aboriginal Community Engagement Initiative
- French Language Services Initiative†
- Critical Care Initiative†
- Primary Care Initiative†

† ***A Ministry of Health and Long-Term Care condition of funding is the selection of an individual to lead each of these projects. Project leads are provided with work space within the LHIN offices.***

Accreditation Canada

The SE LHIN has maintained its accreditation from Accreditation Canada – becoming the first LHIN in the province to do so.

2012/13 Audited Financial Statements

An external audit was conducted by Deloitte & Touche LLP in April 2013. A copy of the auditor's report is provided in the following section of this document. The results of the audit for the 2012/2013 fiscal year were very positive. The South East LHIN ended the fiscal year in a balanced financial position.

Financial statements of

South East Local Health Integration Network

March 31,2013

Deloitte

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Independent Auditor's Report

To the Members of the Board of Directors of the
South East Local Health Integration Network

We have audited the accompanying financial statements of the South East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2013, and the statements of financial activities, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

South East Local Health Integration Network
March 31,2013

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Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of LHIN as at March 31,2013, and the results of its financial activities, changes in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

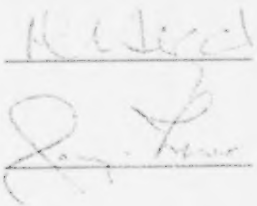
Chartered Professional Accountants, Chartered Accountants
Licensed Public Accountants
May 27,2013

South East Local Health Integration Network

Statement of financial position
as at March 31, 2013

	2013 $	2012 $
Financial assets		
Cash	1,087,305	1,674,708
Accounts receivable (Note 3)	54,990	57,001
	1'142,295	1,731,709
Liabilities		
Accounts payable and accrued liabilities (Note 4)	596,707	1,121,742
Due to MOHLTC (Note 5)	318,212	347,744
Due to the LHIN Shared Services Office (Note 7)	9,792	
Deferred capital contributions (Note 8)	393,052	505,585
Obligations under capital lease (Note 16)	264,038	290,568
	1,581,801	2,265,639
Net debt	(439,506)	(533,930)
Commitments (Note 15)		
Non-financial assets		
Prepaid expenses	46,454	28,345
Tangible capital assets (Note 9)	393,052	505,585
	439,506	533,930
Accumulated surplus		

Approved by the Board



Donna Segal
Board Chair

Ian Fraser
Audit Committee Chair

The accompanying notes to the financial statements are an integral part of these financial statements.

South East Local Health Integration Network

Statement of financial activities
year ended March 31, 2013

	Budget (Note 10)	2013 Actual	2012 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 11)	1,041,073,514	1,099,257,331	1,070,700,326
Operations of LHIN (Notes 5, 10 and 12)	4,543,169	4,534,906	4,778,389
Enabling Technologies (Note 6a)		580,000	600,000
Emergency Department (Note 6b)		75,000	75,000
Aboriginal Initiative (Note 6c)	15,000	15,000	15,000
ER/ALC Initiative (Note 6d)		100,000	100,000
French Language Services Initiative (Note 6e)	106,000	106,000	106,000
Critical Care Initiative (Note 60		75,000	75,000
Primary Care Initiative (Note 6g)		75,000	43,750
Chronic Disease Management (Note 6h)		329,119	
Behavioural Support Ontario			750,000
Amortization of deferred capital contributions (Note 8)		120,796	119,491
	1,045,737,683	1'105,268,152	1,077,362, 956
Funding repayable to the MOHLTC Ontario (Note Sa)		(318,212)	(347,744)
	1,045,737,683	1,104,949,940	1,077,015,212
Expenses			
Transfer payments to HSPs (Note 11)	1,041,073,514	1,099,257,331	1,070,700,326
General and administrative (Note 12)	4,543,169	4,655,665	4,895,501
Enabling Technologies (Note 6a)		489,773	569,907
Emergency Department (Note 6b)		51,425	66,110
Aboriginal Initiative (Note 6c)	15,000	15,000	15,000
ER/ALC Initiative (Note 6d)		100,000	100,000
French Language Services Initiative (Note 6e)	106,000	96,835	102,844
Critical Care Initiative (Note 60		72,000	72,912
Primary Care Initiative (Note 6g)		75,000	18,985
Chronic Disease Management (Note 6h)		136,911	
Behavioural Support Ontario			473,627
	1 045,737,683	1,104,949 940	1,077,015,212
Annual surplus and accumulated surplus, end of year			

The accompanying notes to the financial statements are an integral part of these financial statements.

South East Local Health Integration Network

Statement of change in net debt
year ended March 31, 2013

	2013	2012
	$	$
Annual surplus		
Acquisition of tangible capital assets	(8,263)	(3,878)
Amortization of tangible capital assets	120,796	119,491
Increase in prepaid expenses, net	(18,109)	(13,726)
Decrease (increase) in net debt	94,424	101,887
Net debt, beginning of year	(533,930)	(635,817)
Net debt, end of year	(439,506)	(533,930)

The accompanying notes to the financial statements are an integral part of these financial statements.

South East Local Health Integration Network

Statement of cash flows
year ended March 31, 2013

	2013	2012
	$	$
Operating transactions		
Annual surplus		
Less items not affecting cash		
Amortization of tangible capital assets	120,796	119,491
Amortization of deferred capital contribution (Note 8)	(120,796)	(119,491)
Changes in non-cash operating items		
Decrease in accounts receivable	2,011	8,588
Increase in prepaid expenses	(18,109)	(13,726)
(Decrease) increase in accounts payable and accrued liabilities	(525,035)	306,306
(Decrease) increase in due to MOHLTC	(29,532)	45,247
Increase (decrease) in due to the LHIN Shared Services Office	9,792	(19,552)
	(560,873)	326,863
Capital transaction		
Acquisition of tangible capital assets	(8,263)	(3,878)
Financing transactions		
Increase in deferred capital contributions (Note 8)	**8,263**	3,878
Repayment of obligations under capital lease	**(26,530)**	(25,239)
	(18,267)	21,361
Net change in cash	(587,403)	301,624
Cash, beginning of year	1,674,708	1,373,084
Cash end of year	1,087,305	1,674,708

The accompanying notes to the financial statements are an integral part of these financial statements.

South East Local Health Integration Network

Notes to the financial statements

March 31, 2013

1. Description of business

The South East Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the South East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into a Performance Agreement with the Ministry of Health and Long-Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas based on where residents primarily received their care (98% of all South East LHIN residents obtain care from local health service providers). The LHIN allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion.

The LHIN is home to over 500,000 people and has a geographic area which spans 19,473 square kilometers; the South East LHIN is the fourth largest geographic local integration network. The LHIN serves approximately 3.8% of Ontarians who live, in almost equal proportion, along a ribbon of more urban areas following Highway 401, or in small rural communities located across the remainder of the area. The LHIN encompasses the areas of Hastings, Prince Edward, Lennox and Addington, Frontenac, Leeds and Grenville Counties, the cities of Kingston, Belleville and Brockville, the towns of Smith Falls and Prescott, and part of Lanark and Northumberland Counties. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Performance Agreement ("Performance Agreement"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account Commencing April1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2013.

The LHIN statements do not include any Ministry managed programs.

2. **Significant accounting policies**

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets and losses in the book value of assets.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or seNices performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at year end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as tangible capita! assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Operations betterments or improvements that significantly increase or prolong the seNice life or capacity of a tangible capital asset are capitalized. Maintenance and repair costs are recognized as an expense when incurred. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized, on a straight line basis, over their estimated useful lives as follow:

Office equipment Computer	5 years
equipment Infrastructure/Web	3 years
developments Leasehold	3 years
improvements	Life of lease

2. Significant accounting policies (continued)

Segment disclosures

The LHIN was required to adopt Section PS 2700- Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of financial activities and within the related notes for both the prior and current year sufficiently disclosed information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the **reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimates and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.**

Adoption of new accounting standards

As at April1, 2012, the LHIN adopted Public Sector Accounting Handbook *Section* PS *1201, "Financial Statement Presentation",* Section PS 2601 *"Foreign Currency Translation",* PS 3410 *"Government Transfers"* and Section PS 3450, *"Financial Instruments".* There was no impact of the adoption of these **new standards on the financial statements.**

3. Accounts receivable

The LHIN at March 31, 2013 has accounts receivable of $54,990 wllicll represents HST receivable for the last quarter of tile fiscal year.

4. Accounts payable and accrued liabilities

At Marcil 31, 2013 the LHIN has accounts payable and accrued liabilities valued at $596,707. This amount represents accounts payable {Trade) $157,875, and accrued liabilities $438,832.

5. Funding repayable to the MOHLTC

In accordance with the Performance Agreement, the LHIN is required to be in a balanced position at **year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the** MOHLTC.

In accordance with the accounting policy related to deferred capital contributions (Note 2) the LHIN has **recognized as revenue ("funding received"), the amortization of deferred capital contributions of** $120,796 (2012- $119,491), and the 2013 deferred revenue from capital contributions of $8,263. This **has resulted in an increase to the overall LHIN Operations revenue as shown in note SA below.**

LHIN Operations base funding (budget) for 2013 after adjustments was $4,543,169 (Note 10).

In 2012 e-Health Ontario provided funding directly to the LHIN for Project Management Office activities; in 2013, the MOHLTC provided this funding direct to the LHIN.

5. **Funding repayable to the MOHLTC (continued)**

(a) The amount repayable to the MOHLTC is made up of the following components:

	Funding received	Related exeenses	2013 Excess funding
	$	$	$
Transfer payments to HSPs	1,099,257,331	1,099,257,331	
LHIN operations (Note 12a)	4,655,702	4,655,665	37
Enabling technologies	580,000	489,773	90,227
Emergency department initiative	75,000	51,425	23,575
Aboriginal initiative	15,000	15,000	
ER/ALC Initialive	100,000	100,000	
French Language Services Initiative	106,000	96,835	9,165
Critical Care Initiative	75,000	72,000	3,000
Primary Care Initiative	75,000	75,000	
Chronic Disease Management	329,119	136,911	192,208
	1105 268 152	1104949940	318 212

(b) The amount due to the MOHLTC at March 31 is made up as follows:

	2013	2012
	$	$
Opening balance	317,651	302,497
Funding repaid during the year	(311,651)	(302.497)
One-time funding repayable to MOHLTC	318,175	315,272
LHIN Operations funding repayable to MOHLTC	37	2,379
Closing balance	318,212	317,651

(c) The amount due e-Health Ontario at March 31 is made up as follows:

	2013	2012
	$	$
Due to e-Health Ontario, beginning of year	30,093	
Paid toe-Health Ontario during year	(30,093)	
Funding repayable toe-Health Ontario related current year activities		30,093
Closing balance		30,093

6. a) *Enabling Technologies Initiative (formerly known as e-Health)*

During fiscal 2013, the LHIN received funding in the amount of $580,000 ($600,000 in 2012) for a **local Project Management Office. These funds were used toward initiatives in support of its strategic** Enabling Technologies Plan as defined in its Integrated Health Services Plan. Unspent funds, amounting to $90,227 ($30,093 in 2012) at year end, are repayable to the MOHLTC.

	2013	2012
	$	$
Expenses		
Salaries and benefits	302,157	308,860
Consulting seruices		126,775
Travel	21,908	15,308
Meeting expenses	5,270	3,345
Other	160,438	115,619
	489 773	569,907

b) *Emergency Department Initiative*

During fiscal 2013, the LHIN received funding in the amount of $75,000 ($75,000 in 2012) from the **MOHLTC. These funds were used toward initiatives in support of the strategic Emergency** Department Initiative and fell under the Access to Specialized Medical Services, within the Integrated Health Services Plan "Priority for Change". Unspent funds, amounting to $23,575 ($8,890 in 2012) at year end, are repayable to the MOHLTC.

	2013	2012
	$	$
Expenses		
Consulting	49,500	63,300
Travef	1,925	
Other		2,810
	51 425	66 110

c) *AboriginalInitiative*

During fiscal 2013, the LHIN received funding in the amount of $15,000 ($15,000 in 2012) from the MOHLTC. These funds were used toward planning activities including assistance with the Metis Health Survey and engagement with the Aboriginal community including the newly formed Indigenous Council at the Napanee CHC in support of the Integrated Health Services Plan "Priority for Change".

	2013	2012
	$	$
Expense		
Other	15,000	15,000
	15 000	15,000

6. (continued)

d) ERIALC Initiative

During fiscal2013, the LHIN received funding in the amount of $100,000 ($100,000 in 2012) from the MOHLTC. These funds were used in support of the ER/ALC Strategy.

	2013	2012
	$	$
Expense		
Salary and benefits	99,387	100,000
Travel	613	
Closin9 balance	100,000	100,000

Actual expenditures incurred as part of the ER/ALC Initiative activities were in excess of the $100,000 funding provided by the MOHLTC. The total of actual expenses is $106,047 ($147,100 in 2012). The overage of $6,047 ($47,100 in 2012) has been funded through LHIN Operations base.

	2013	2012
	$	$
Expenses		
Salaries and benefits	99,387	135,594
Travel	2,858	5,762
Meeting expenses	1,347	1,366
Other	2,455	4,378
	106 047	147 100

e) French Language Services Initiative

During fiscal 2013, the LHIN received funding in the amount of $106,000 ($106,000 in 2012) from the MOHLTC. These funds were used in support of the French Language Services Strategy. Unspent funds, amounting to $9,165 ($3,156 in 2012) at year end, are repayable to the MOHLTC.

	2013	2012
	$	$
Expenses		
Salaries and benefits	76,379	82,663
Travel	3,724	4,564
Meeting expenses	128	113
Other	16,604	15,504
	96 835	102,844

6. (continued)

f) Critical Care Initiative

During fiscal 2013, the LHIN received funding in the amount of $75,000 ($75,000 in 2012) from the MOHLTC. These funds were used in support of the Critical Care Strategy. Unspent funds, amounting to $3,000 ($2,088 in 2012) at year end, are repayable to the MOHLTC.

	2013	2012
	$	$
Expenses		
Consulting	72,000	72,000
Travel		912
	72,000	72,912

g) Primary Care Initiative

During fiscal 2013, the LHIN received in-year funding in the amount of $75,000 ($43,750 in 2012) from the MOHLTC. These funds were used toward planning and engagement with Primary Health Care providers in support of the Integrated Health Services Plan "Priority for Change."

	2013	2012
	$	$
Expenses		
Consulting	72,000	18,000
Travel	2,480	970
Meeting expenses	480	
Other	40	15
	75,000	18,985

Actual expenditures incurred as part of the Primary Care Initiative activities were in excess of the $75,000 funding provided by the MOHLTC. The total of actual expenses is $76,705 ($43,750 in 2012). The overage of$1,705 has been funded through LHIN Operations base.

	2013	2012
	$	$
Expenses		
Consulting	72,000	43,750
Travel	4,185	
Meeting expenses	480	
Other	40	
Closing balance	76,705	43,750

h) Chronic Disease Management

In February 2013 (fiscal 2013), the LHIN received funding of $329,119 to enhance Chronic Disease Management and the Ontario Diabetes Strategy for Ontarians in support of the Integrated Health Services Plan. Unspent funds, amounting to $192,208 at year end, are repayable to the MOHLTC.

	2013
	$
Expenses	
Salaries and benefits	59,867
Travel	1,329
Other	75,715
	136 911

7. Related party transactions

LHIN Shared SeiVices Office (LSSO)

The LSSO is a division of the Toronto Central LHIN and, as such, is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable from (payable to) the LSSO. This is all done pursuant to the Shared Service Agreement the LSSO has with all the LHINs.

LHIN Collaborative (LHINC)

LHINC was formed in fiscal2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC is to support the LHINs in:

- **fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system;**
- **their role as system manager;**
- **where appropriate, the consistent implementation of provincial strategy and initiatives;**
- **the identification and dissemination of best practices.**
- LHINC is a LHIN-led organization and accountable to the LHINs. LHINC is funded by the LHINs with support from the Ministry of Health and Long-Term Care.

LHINC is a division of Toronto Central LHiN and as such is subject to the same policies, guidennes and directives as the Toronto Centra! LHIN.

8. Deferred capital contributions

	2013	2012
	$	$
Balance, beginning of year	505,585	621,198
Capital contributions received during the year	8,263	3,878
Amortization for the year	(120,796)	(119,491)
Balance, end of year	393,052	505,585

9. Tangible capital assets

	Cost	Accumulated amortization	2013 Net book value	2012 Net book value
	$	$	$	$
Office equipment	408,006	272,494	135,512	207,288
Computer equipment	130,670	123,868	6,802	11,739
Leasehold imerovements	358,197	107,459	250,738	286,558
	896 873	503 821	393 052	505 585

10. **Budget figures**

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of Financial Activities reflect the initial budget at **April1**, 2012. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirement. During the year the government approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $1,099,257,331 is made up of the following:

	$
Initial HSP funding budget	1,041,073,514
Adjustment due to announcements made during the year	58,183,817
Total HSP funding budget	1,099,257,331

The total operating budget of $4,543,169 is made up of the following:

	$
Initial budget	4,543,169
Additional funding received during the year	
Total bud et	4,543,169

11. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,099,257,331 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

Operation of Hospitals	721,433,597	703,298,709
Grants to compensate for Municipal Taxation-		
Public Hospitals	190,725	190,725
Long-Term Care Homes	170,990,709	170,862,497
Community Care Access Centres	108,497,833	102,084,846
Community Support Services	30,132,287	29,121,695
Assisted Living Services in Supportive Housing	2,048,566	2,043,566
Community Health Centres	23,054,049	22,200,869
Community Mental Health Addictions Program	42,909,565	40,897,419
	1,099,257,331	1,070,700,326

12. General and administrative expenses

(a) The Statement of financial activities presents expenses by function. The following classifies general and administrative expenses by object, as follows:

	2013	2012
	$	$
Program based		
Salaries	3,321,827	3,546,649
Consulting and LHIN-based projects	135,185	46,194
	3,457,012	3,592,843
Shared services	294,616	435,080
Collaborative	47,500	26,971
Other (details listed below)	218,153	205,855
Occupancy	214,889	212,698
Office equipment and supplies	133,310	132,588
Board per diem	68,700	71,400
Public relations	49,412	52,123
Mail, courier and telecommunications	51,277	46,452
	4,534,869	4,776,010
Amortization	120,796	119,491
	4 655 665	4,895,501

(b) The breakdown of "Other" general and administrative expenses listed in the table above are:

	2013	2012
	$	$
Training and development	86,827	52,829
Travel	114,430	111,507
Recruitment	10,709	10,622
Insurance	6,634	17,768
Other miscellaneous	(447)	13,129
	218 153	205,855

(c) The total expenses related to governance is as follows, and are included in the expenses listed in Note 12(a) above:

	2013	2012
	$	$
Board chair per diems	31,500	34,500
All other per diems	37,200	36,900
Total per diems	68,700	71,400
Other administrative costs	42,559	53,797
Total governance expenditures	111,259	125,197
~~**Overhead- salaries, benefits, accommodations and shared services**~~	154,417	153,519
Total governance related costs	265,676	278,716

(d) The total occupancy and shared service costs are reduced from actual expenses in Note 12(a) above, due to partial cost sharing with ancillary funded projects for project staff that **utilize office space and or shared services during the year.**

13. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2013 was $274,129 (2012- $279,712) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan as of December 31, 2011. At that time, the plan was fully funded.

14. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration* Act.

15. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Minimum lease payments due under the building lease as follows:

	$
2014	224,064
2015	224,064
2016	224,064
2017	224,064
2018	224,064
Thereafter	653,520
	1,773,840

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31,2013, the LHIN had signed Performance Agreements with all Hospitals and Community Agencies for the next one to three years dependent upon the specific sector. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from MOHLTC.

16. Obligations under capital lease

The LHIN has a lease under the provision of capital lease of leasehold improvements. The cost of this lease is included in equipment and the related liabilities are included in long-term debt to reflect the effective acquisition and financing of these items. The lease on the building expires in February, 2021.

The present value of future minimum rentals are as follows:

	$
2014	40,456
2015	40,456
2016	40,456
2017	40,456
2018	40,456
Thereafter	117,997
Future minimum lease payments	320,277
Less: amount representing interest	(56,239)
Present value of future minimum rentals	264,038

Principal payments required on this long-term debt for the next five years are as follows:

	$
2014	27,887
2015	29,314
2016	30,814
2017	32,390
2018	34,048
Thereafter	109,585
	264,038

South East Local Health Integration Network

Statement of financial position
as at March 31, 2012

	2012	2011
	$	$
Financial assets		
Cash	**1,674,708**	1,373,084
Accounts receivable (Note 3)	**57,001**	65,589
	1,731,709	1,438,673
Liabilities		
Accounts payable and accrued liabilities (Note 4)	**1,121,742**	815,436
Due to MOHLTC and eHealth Ontario (Note 5)	**347,744**	302,497
Due to the LHIN Shared Services Office (Note 7)	**-**	19,552
Deferred capital contributions (Note 8)	**505,585**	621,198
Obligations under capital lease (Note 16)	**290,568**	315,807
	2,265,639	2,074,490
Net debt	**(533,930)**	(635,817)
Non-financial assets		
Prepaid expenses	**28,345**	14,619
Capital assets (Note 9)	**505,585**	621,198
	533,930	635,817
Accumulated surplus	**-**	-

Approved by the Board:

Wynn Turner
Board Chair

Ian Fraser
Audit Committee Chair

South East Local Health Integration Network

Statement of financial activities
year ended March 31, 2012

	Budget (unaudited) (Note 10)	2012 Actual	2011 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 11)	984,696,442	1,070,700,326	1,017,913,350
Operations of LHIN (Notes 5, 10 and 12)	4,782,269	4,778,389	4,302,588
e-Health (Note 6a)	-	600,000	1,325,000
Emergency Department (Note 6b)	-	75,000	75,000
Aboriginal Initiative (Note 6c)	15,000	15,000	15,000
ER/ALC Initiative (Note 6d)	-	100,000	100,000
French Language Services Initiative (Note 6e)	106,000	106,000	110,000
Critical Care Initiative (Note 6f)	-	75,000	75,000
Primary Care Initiative (Note 6g)	-	43,750	-
Behavioural Support Ontario (Note 6h)	-	750,000	-
Amortization of deferred capital contributions (Note 8)	-	119,491	147,905
	989,599,711	1,077,362,956	1,024,063,843
Funding repayable to the MOHLTC and eHealth Ontario (Note 5a)	-	(347,744)	(302,497)
	989,599,711	1,077,015,212	1,023,761,346
Expenses			
Transfer payments to HSPs (Note 11)	984,696,442	1,070,700,326	1,017,913,350
General and administrative (Note 12)	4,782,269	4,895,501	4,447,604
e-Health (Note 6a)	-	569,907	1,039,120
Emergency Department (Note 6b)	-	66,110	73,937
Aboriginal Initiative (Note 6c)	15,000	15,000	15,000
ER/ALC Initiative (Note 6d)	-	100,000	100,000
French Language Services Initiative (Note 6e)	106,000	102,844	99,310
Critical Care Initiative (Note 6f)	-	72,912	73,025
Primary Care Initiative (Note 6g)	-	18,985	-
Behavioural Support Ontario (Note 6h)	-	473,627	-
	989,599,711	1,077,015,212	1,023,761,346
Annual surplus and closing accumulated surplus	-	-	-

South East Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2012

	2012	2011
	$	$
Annual surplus	-	-
Acquisition of capital assets	**(3,878)**	(479,682)
Amortization of capital assets	**119,491**	147,905
Increase in prepaid expenses	**(13,726)**	(8,695)
Decrease (increase) in net debt	**101,887**	(340,472)
Opening net debt	**(635,817)**	(295,345)
Closing net debt	**(533,930)**	(635,817)

South East Local Health Integration Network

Statement of cash flows
year ended March 31, 2012

	2012	2011
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**119,491**	147,905
Amortization of deferred capital contribution (Note 8)	**(119,491)**	(147,905)
Changes in non-cash operating items		
Decrease (increase) in accounts receivable	**8,588**	(65,589)
Decrease in due from LHIN Shared Services Office	-	1,895
Increase in prepaid expenses	**(13,726)**	(8,695)
Increase (decrease) in accounts payable and accrued liabilities	**306,306**	(38,712)
Increase in due to MOHLTC and eHealth Ontario	**45,247**	173,750
Increase (decrease) in due to the LHIN Shared Services Office	**(19,552)**	19,552
	326,863	82,201
Capital transaction		
Acquisition of capital assets	**(3,878)**	(479,682)
Financing transactions		
Increase in deferred capital contributions (Note 8)	**3,878**	479,682
Increase in obligations under capital lease	-	319,178
Repayment of obligations under capital lease	**(25,239)**	(3,371)
	(21,361)	795,489
Net change in cash	**301,624**	398,008
Cash, beginning of year	**1,373,084**	975,076
Cash, end of year	**1,674,708**	1,373,084